across the categories of patients being pooled.

(4) The distribution of payments to physicians from the risk pool is not calculated separately by patient category.

(5) The terms of the risk borne by the physician or physician group are comparable for all categories of patients being pooled.

(h) *Periodic surveys of current and former enrollees.* An M+C organization must conduct periodic surveys of current and former enrollees where substantial financial risk exists. These periodic surveys must—

(1) Include either a sample of, or all, current Medicare/Medicaid enrollees in the M+C organization and individuals disenrolled in the past 12 months for reasons other than—

(i) The loss of Medicare or Medicaid eligibility;

(ii) Relocation outside the M+C organization's service area;

(iii) For failure to pay premiums or other charges;

(iv) For abusive behavior; and

(v) Retroactive disenrollment.

(2) Be designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis;

(3) Measure the degree of enrollees/disenrollees' satisfaction with the quality of the services provided and the degree to which the enrollees/disenrollees have or had access to the services provided under the M+C organization; and

(4) Be conducted no later than 1 year after the effective date of the M+C organization's contract and at least annually thereafter.

(i) *Sanctions.* An M+C organization that fails to comply with the requirements of this section is subject to intermediate sanctions under subpart O of this part.

§ 422.210 Disclosure of physician incentive plans

(a) *Disclosure to HCFA*—(1) *Basic requirement.* Each M+C organization must provide to HCFA descriptive information about its physician incentive plan in sufficient detail to enable HCFA to determine whether that plan complies with the requirements of § 422.208. Reporting should be on the HCFA PIP Disclosure Form (OMB No. 0938–0700).

(2) *Content.* The information must include at least the following:

(i) Whether services not furnished by the physician or physician group are covered by the incentive plan.

(ii) The type or types of incentive arrangements, such as, withholds, bonus, capitation.

(iii) The percent of any withhold or bonus the plan uses.

(iv) Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection.

(v) The patient panel size and, if the plan uses pooling, the pooling method.

(vi) If the M+C organization is required to conduct enrollee surveys, a summary of the survey results.

(3) *When disclosure must be made to HCFA.* An M+C organization must disclose annually to HCFA the physician incentive arrangements that are effective at the start of each year. In addition, HCFA does not approve an M+C organization's application for a contract unless the M+C organization discloses the physician incentive arrangements effective for that contract.

(b) *Disclosure to Medicare beneficiaries—Basic requirement.* An M+C organization must provide the following information to any Medicare beneficiary who requests it:

(1) Whether the M+C organization uses a physician incentive plan that affects the use of referral services.

(2) The type of incentive arrangement.

(3) Whether stop-loss protection is provided.

(4) If the M+C organization was required to conduct a survey, a summary of the survey results.

§ 422.212 Limitations on provider indemnification.

An M+C organization may not contract or otherwise provide, directly or indirectly, for any of the following individuals, organizations, or entities to indemnify the organization against any civil liability for damage caused to an enrollee as a result of the M+C organization's denial of medically necessary care: